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JOURNAL FOR NURSES

JULY 1940

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IN *This* ISSUE

July 1940 Vol. 3, No. 10

A JOURNAL RN FOR NURSES

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Debits AND CREDITS

INDIVIDUAL SUPPORT

Dear Editor:

We, as professional women, have a right to expect decent standards—a fair salary, adequate living conditions, and respect...

Our professional organization could mean so much and yet it seems to mean so little. The labor union is not the solution to our problems. I believe that nurses have only turned to the union in desperation.

But how can the A.N.A. take effective action when we, as individuals show no gumption? How can the A.N.A. function regarding the staff nursing problem when the local district gives bridge parties, musicals, and pink teas—instead of devoting its programs to real local nursing problems? So many districts also make the mistake of devoting all their efforts toward the problems of private-duty nursing. The staff nurse pays dues to the organization, too.

Let's turn over a new leaf and make 1940 show some real and constructive changes.

R.N., Hansen, Idaho

GENERAL DUTY

Dear Editor:

Although I am a private nurse, I frequently do general duty because it brings me up-to-date as no special case ever can. I know that general duty nurses often work twelve-hour days instead of the nine hours they signed up for. But would any nurse leave a floor while she was still needed? A sudden flood of new patients is never, seemingly, justification for additional nurses. Which explains why so many patients prefer a hospital with students...

I believe that if we used our A.N.A. properly we could mend all this. We don't reap all the advantages such a strong and well-woven association could give us.

Why can't the A.N.A. be developed to meet our needs? If we used it as we should we wouldn't have the A.F. of L. and C.I.O. to worry about. We would be using our own vehicle for our own progress and would need no outside help...

Whatever we may think of labor unions, we shouldn't blame nurses for taking the only apparent road open to them. Ideals and professional standing have such a disconcerting habit of fading suddenly into the fog produced by a weary body and a too-slim pay envelope—to say nothing of that all-gone feeling of having been forgotten by one's own organization.

I am not criticizing the A.N.A. But I want to see it "bloom in all its glory" instead of remaining uncultivated by you and me and the rest of the rank and file of nursing. We must start with our little bit at alumnae meetings. We must speak for ourselves and go after what we need. This and nothing else will send the blood of new movement through the network of the A.N.A...

Edna Davis, R.N.
Skyland, N.C.

SOLUTION?

Dear Editor:

I am in favor of organized labor, but I do not see the place of unions in the nursing field. I wonder how many nurses who join unions do so by hearsay, find out too late what labor is all about...

Like any other true nurse, I feel we should be loyal to our own A.N.A. . . . Let us all work together and keep our problems within our own professional scope. If, in New York State, the only solution to nursing problems is offered by labor unions, let them do as they see fit—but not without careful study and investigation. For the rest of us, let's stick to professional organizations.

Margaret Houghton, R.N.
Milwaukee, Wis.

PARADOX

Dear Editor:

Where I am employed we assemble each weekday morning in the classroom for a five-minute chapel service. We repeat the Nightingale Pledge, sing a hymn, and say the Lord's Prayer. We pledge our-

selves to do all in our power to elevate the standards of our profession. But we work broken shifts which keep us out of private life twelve and fourteen hours a day in order to complete eight hours of duty . . .

R.N., Los Angeles, Calif.

OPEN MEETINGS

Dear Editor:

There is one way to eliminate the idea of "Why go to meetings when no one is allowed to discuss anything?" The district organization should hold open meetings for all nurses working in that area, whether or not they are A.N.A. members. At these meetings nurses should be encouraged to discuss present-day problems. Such a policy would stimulate wider interest in the A.N.A. and eventually enlarge its membership.

Sylvia Behr, R.N.
Brooklyn, N.Y.

I.O.U.

Dear Editor:

I would like to hear from other States whether or not they have trouble collecting for private-duty wages. What per cent of private-duty nurses have difficulty doing so?

Is there any protection for the private-duty nurse in any State?

Leona O. Peak, R.N.
Quincy, Ill.

CHEERS

Dear Editor:

To you and your staff for publishing it, and to Elizabeth Berman for writing it, a loud and rousing cheer for the article, "Dear Mrs. Brande—."

Mrs. Berman voices my convictions exactly, only she states them much more graciously than I did when I first read Mrs. Brande's opinion. Thank you for both sides of the argument . . .

Mary E. Thomas, R.N.
Franklin, Pa.

SHORT SLEEVES

Dear Editor:

I am interested to know what the majority of nurses in the public-health field think about using short-sleeves on uniforms. It seems apparent that the tendency in the summer is the short sleeve.

Nurses' uniforms have been copied by people in many unprofessional fields—with the exception that most of the copies have short sleeves. It seems to me that the only thing which distinguishes the professional nurse's uniform is the long sleeve.

I am very proud of my uniform and I think every nurse should give this question serious consideration.

Mildred S. Treuter, R.N.
Rahway, N.J.

FULL DRESS

Dear Editor:

Does not the uniform of a nurse indicate purity and cleanliness? Why then do some nurses wear their uniforms on the street, when off duty?

In this city I have seen some in full uniform, including cap, riding street cars to and from work. When not wearing caps, they are often mistaken as waitresses.

This conduct is unprofessional and undignified . . .

F. F. Williamson, R.N.
Kansas City, Mo.

DUTY CASES

Dear Editor:

Your recent discussion of nurses' duty cases interested me. Perhaps your readers would like to hear how I made up a case to suit my own particular needs . . .

Because I work mostly in a hospital, I need only a small case which I purchased at a local leather store. I took the equipment I thought I would need into the store and they fitted the bag with an insert containing loops to fit the various articles. This insert fastens to the top side of the lid with a tab and snap, allowing sufficient room between the insert and lid for instruments. The lid has a pocket on the inside where I carry any papers I care to—such as routine orders of different doctors—as well as a piece of oiled silk to lay my hypo on when I want to keep the needle sterile with alcohol sponge.

The equipment I chose to carry includes: A 2 c.c. hypo in sterile, round metal case; pen-type flashlight; rectal and oral thermometer; straight razor for "preping"; straight forceps; nail clip-

IRON IN HUMAN NUTRITION

● Like certain other essential minerals, iron performs several vital physiologic functions in the human body. Certainly the best-known, as well as a most important role of iron, is in the formation of hemoglobin, the blood constituent which effects oxygen transport.

The destruction and regeneration of hemoglobin is a continuous process. It has been estimated that daily the adult human destroys and regenerates 29 grams of hemoglobin, an amount containing about 90 milligrams of iron (1). It is a fortunate circumstance that most of this iron is conserved for re-use. However, iron lost in the regeneration process must be supplied by foods or from body stores of this element made possible by a liberal supply of iron in the diet.

Dietary iron deficiency may produce a definite type of anemia due to inability of the organism to elaborate an adequate amount of hemoglobin. This kind of anemia is not uncommon in infants, or in older individuals during periods in the life cycle in which body demands for iron are unusually heavy. Balance studies have permitted the following estimates of daily iron requirements for normal persons (2):

Infant (per pound body weight)	0.36 mg.
Preschool child (per pound body weight)	0.27 mg.
Boys and girls, 5-11 years	9–11 mg.
Boys over 11 years	13 mg.
Girls over 11 years	13–15 mg.
Man	12–15 mg.
Woman before menopause	17 mg.
Pregnant woman	20 mg.
Nursing woman	17–20 mg.
Woman after menopause	12–15 mg.

In securing these necessary daily supplies of dietary iron, unfortunately we cannot be solely guided by the total iron content of the diet. It should be remembered that probably not more than about 60 per cent of the total iron present in a mixed diet can be diverted to the body's uses (2), even though with individual foods this percentage of "ionogenic iron" may be quite high (3). Consequently, in practical nutrition, to obtain an adequate intake of this essential mineral about twice the estimated daily requirement of iron should be received by way of the daily ration.

By intelligent diet planning, the normal individual can readily attain an optimal supply of iron. Foods rich in content of this mineral (2) should be given a prominent place in the ration. It is perhaps needless to state that the canned varieties of these foods will also prove both valuable and convenient in the attainment of the daily amounts of this essential element now considered to be necessary for complete nutrition.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

REFERENCES

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(2) 1939. Food & Life, Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.

(3) 1940. J. Nutrition 19, 449.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-first in a series, which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

pers; bandage scissors. In the bottom of the case I carry an eight-inch ruler for midnight lines; a 10 c.c. vial of sterile distilled water for hypos (I use a liver-extract vial); a small bottle of alcohol; sterile cotton pledgets; ampoule files; tourniquet; nail file; a pencil; and usually some half-inch adhesive and two-inch bandage. I did not provide a place for my pens as I find it is more convenient to carry them in my pocket.

The case is a regular fitall toilet case which may be had with a zipper or snap fastener. I prefer the snap because it can be opened more readily when in a hurry.

F. L. Herrick, R.N.
National City, Calif.

[*Mr. Herrick is a male nurse.*—THE EDITORS]

P.N. COMPETITION

Dear Editor:

I have heard a number of nurses predict that after the practical nurse gets her license (in New York State), there will be a much greater demand for nurses who will accept a wage of as little as $18 or $20 a week. Won't this force graduates to wait much longer between cases?

Let's hear from other nurses on this subject . . .

R.N., Buffalo, N.Y.

BRIGHT SPOT

Dear Editor:

I am certainly glad that it still takes all kinds of people to make a world.

Can you just picture what a drab place this old earth would be if all that was left to a person was to look forward, day in and day out, to "Less Sweetness and Light?" Thank heaven there are still a few bright spots left around like Elizabeth Berman to revive one's spirits and help one along.

If people would only realize that a few kind words can go such a long way. Who knows, maybe some day the chronic complainer may really learn that constructive criticism has taken the place of ridicule and petty grievances.

H. Moreau, R.N.
Sewickley, Pa.

"CALL" SUCCEEDS

Dear Editor:

I want to thank all the R.N. readers who responded to my notice in "Calling All Nurses" last December. I now have 350 lovely cards added to my collection!

Evelyne P. Page, R.N.
Gaffney, S.C.

SELF-DEFENSE

Dear Editor:

Hurray! hurray! for the article "Dear Mrs. Brande—" by Elizabeth Berman.

All I can say is that I'm sure those are the sentiments of nine out of ten nurses—all of whom could relate similar experiences. We all feel just the way that article expresses it . . .

Esther V. Smith, R.N.
St. Albans, N.Y.

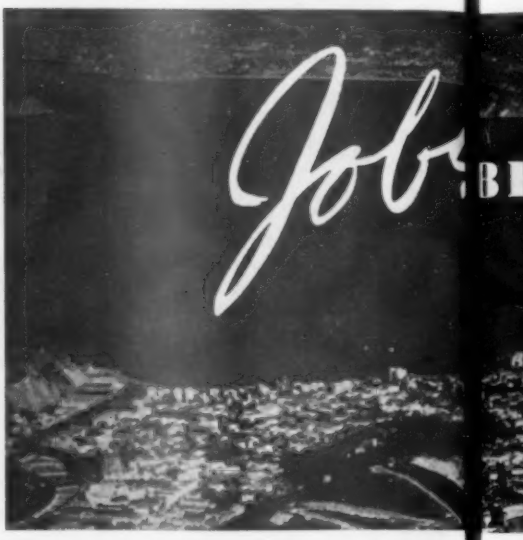
Dear Editor:

Articles such as "Less Sweetness and Light" are good for us. How else can we maintain any perspective on our work? I think any nurse who took offense at Mrs. Brande's impressions of us just "can't take it."

R.N., Boston, Mass.

BY JEAN MARTIN WHITE, R.N.

If you're the pioneer type, you'll find challenge and adventure in this story of nursing careers in South America. There are opportunities below the Equator, says this author, for qualified candidates... Mrs. White was formerly in the nursing school of Mt. Vernon Hospital, New York.



• President Roosevelt's reassertion of the Monroe Doctrine may momentously affect nursing's future. So predict many authorities on Latin America, who see the Administration's attitude as an awakening of Uncle Sam to his responsibilities toward his sister South American republics. If they are right—and there is little evidence to the contrary—the United States and its nurses may shortly be displaying a more active regard for South America's welfare, especially its health.

Never has nursing been so challenged. Construct in your mind's eye a continent of over 80 million potential patients—almost entirely without adequate nursing care. Picture ten nations, blessed with the riches to purchase this necessity, but prevented from doing so by their own backwardness.

To the R.N. who is willing to pioneer, this brave new world is a land of opportunity. From the mountain valleys with their *Verruga Peruana* to the ports with their bubonic plague, disease at its deadliest challenges the most skillful techniques. At almost any jungle mission station, the nurse can play Florence Nightingale in a tropic setting. If she prefers to gamble for big stakes, she can try private duty in the coastal cities. Or she can taste South America in all its effulgent variety amid the comforts of a dispensary maintained by an American industrial firm.

Before rushing to pack your bags, however, be advised that there are some flies in the ointment of a South American career.

The New Deal's "good neighbor" policy, for instance, has so far worked on only one side—ours. From the other, the nurse frequently encounters some remarkable displays of professional jealousy. Take the example of a friend of mine, who accepted appointment as supervisor of a Brazilian hospital. She was met at the pier by a delegation from the Graduate Nurses' Association, which forcibly tried to prevent her

from landing! This hostility toward Americans is reflected in local nursing legislation. Colombian and Peruvian laws give preference in employment to graduates of their own schools. Brazil legally limits the "alien's" tenure to two years.

Another annoyance—though hardly more than that—is the lack of respect

eans." Although their fatherlands are at war, these friendly enemies on occasion have united to keep control of a district's medical facilities. Thus, in Rio de Janeiro, they jointly operate the neutrally-named "Strangers' Hospital."

All this tends to limit nursing opportunities for Americans. Even so, experts see the scales turning in favor of

Palmer, Black Star

for nurses among the populace. The Spanish-American has no word for professional woman. Any woman who works with her hands is a menial—and that's that. Peru goes so far as to classify nurses officially as "servants." So when you set sail for southern shores you may leave your professional standing in the Statue of Liberty's lap.

Then, the British and Germans, who have had their own hospitals and training schools in South America for years, don't like the idea of a third group horning in. Everywhere the English have penetrated they have established their own hospitals. Lately, the Nazis have lifted a leaf out of John Bull's book; particularly in Brazil. At Porto Alegre, their nursing school is now turning out "Aryan Brazilians" to compete with England's "Anglo-Argentin-

this country. The reason is plain: Not a single South American nation is prepared to supply its own nursing needs. The repeated failure of Colombia's attempts to set up a public-health system is one demonstration of this weakness. Elaborate public-health programs, planned for Bolivia, Brazil, and Venezuela are hamstrung because of the lack of trained personnel.

Where is the latter to be obtained?

Not from native schools, which are hopelessly below par. Nor from Europe, which requires every nurse at its command for war purposes. The one remaining source is the United States. Chile recently recognized this by encouraging the importation of American R.N.'S—although ostensibly to train natives to take over. In neighboring countries, the opening of the gates to Amer-

icans awaits only a change of government policy. When it is considered that Bolivia, for instance, has had sixty-one military revolts, ten constitutions, and six assassinated presidents in 72 years, such a change is not altogether an improbability.

At present, however, the outlook is somewhat dimmer. Only four major nursing fields are generally accessible to Americans.

One is the national and municipal hospitals. From many angles, any but administrative posts in these institutions are no bargain. The patients are mostly flotsam and jetsam. Throughout Peru and Bolivia, two-thirds are Indians. An overwhelmingly high ratio is illiterate. Asepsis, nutrition, and hygiene may be observed by their absence. The staffs—usually political jobholders—often show a blithesome disregard for their patients' welfare. Patients distrust their care and the custom of *accompañante* has sprung up. This is a sort of spy system under which a relative or friend lives in the patient's room. His function is to see that the latter gets what is coming to him!

Salaries in these institutions are usually low. Difficulty in collecting wages has taught some nurses to insist upon advance deposit of their pay in an American bank.

A second possibility is mission work among the primitive peoples of the interior. Compensation here runs about $65 or less a month. Living conditions, in some tangled skein of torrid jungle, are almost intolerable. That is why the missions themselves discourage all but the hardiest from undertaking such a career. If you're still interested, the thing to do is write the nearest branch of your church's mission organization.

Many nurses have been impressed by what they believe to be opportunities for private nurses in South American cities. Upper-class patients in these areas are frequently wealthy beyond belief. They regard the local hospitals as fit only for [*Continued on page* 34]

PROBIE

"Now, now, Mrs. Burns—don't get excited!"

GIVE *the Men* A BREAK!

ANONYMOUS

• For some years I have borne the perennial cries of the opposite sex for "equal rights" with gentlemanly grace. But as a man nurse, I think the time has come for me to let out a laugh—of the horse variety. Equal rights indeed! When I consider how my colleagues have fared under nursing's petticoat government, I yearn for the good old days when women were just wives and mothers.

Compared to us, the henpecked husband is freedom personified. Nearly every nursing field is tied to female apron strings. If that were not bad enough, the average man has to wage his uphill fight for professional existence to the accompaniment of steady abuse.

It would seem to me more beneficial all around if someone would remove the misapprehensions under which some of the ladies appear to be laboring. That is the purpose of this article.

One of the major delusions of our fair sisters in white is that our qualifications are somehow inferior to their own. Although the origin of this myth is as inexplicable as woman herself, it recurs among the feminine section of the profession with annoying frequency.

The commonest misconception is that we spend only about a third as much time in training. Now there are over fifty nursing schools in the United States that accept men students. Not one of these, to my knowledge, offers an R.N. for a year of study. A few may require only two years—but that is also true of a similar proportion of women's schools. By far the majority insist upon the approved three-year course. The curriculum for men differs only in omitting obstetrics and gynecology (in some schools), for which urology and psychiatry are substituted.

Recognizing these facts, some women nurses go even further. "But man doesn't *belong* in nursing," they argue.

This is about as sensible as Grandpa's bromide about Grandma's place being in the home. The truth is that we've been around for a long time; perhaps before the ladies. As far back as 1799, Magdeburg, Germany, had a State training school for men. That was forty years before Florence Nightingale proved that women also could nurse. And if you remember your history, you know that Clara Barton had quite a time convincing our American army in Civil War days that nursing was fit for females. Yet nearly thirty years previously—in 1837—New York's City Hospital was turning out men nurses. So the theory that men are intruders in nursing is as outmoded as this year's Easter bonnet.

Occasionally, one meets a broad-minded woman who admits that there is room in the profession for both men and women. Unfortunately, she often goes on to explain that we should be satisfied to handle alcoholics, violent manics, or other cases which the ladies shun. As for the "cream," if we were not unreasonable, obdurate men, we would understand that is "for women only." [*Turn the page*]

This philosophy—or propaganda—has been passed on in a thousand ways to our patients and employers. It has erected a pillar of prejudice on which the man nurse bumps his head at nearly every turn.

If he seeks an executive position in a hospital, he quickly discovers that institutions prefer a doctor, a woman nurse, even a layman—to himself. This, although the few of his colleagues who have crashed the gates in this field have displayed outstanding ability. A notable example is Paul R. Zwilling, R.N., president of the American Protestant Hospital Association.

The man nurse generally has a superior education. In the better nursing schools, the ratio of men graduates with college degrees is high—40 per cent, for instance, in Manhattan's Mills School. Men, too, make the best teachers, as the leading universities have proved. But what happens to the man who would teach his profession in a nursing school—even one with an exclusively masculine student body? The record speaks for itself. Only two or three men have been admitted to such posts in the entire United States.

You'd think that at least army service would be a masculine monopoly. But no. The army will not commission us as it does the women. We rate as staff sergeants while the girls cop off the choice rank of major! As yet the Red Cross will not accept us as reservists. Veterans hospitals will not employ us to attend male patients. The navy alone shows signs of enlightenment. Here we have a crack at good jobs as pharmacists' mates.

Economic factors make life even more difficult for us. Many of us are heads of families. Naturally, we require a greater income than the girl who has only herself to support or who is being supported by her husband. But do we get it? Well, you know the answer as well as I do.

Not long ago I was called in on an industrial assignment. It involved complete charge of a six-bed first-aid hospital on a project employing hundreds of workmen. My estimate of a just compensation was $60 a week.

When he heard this figure, the boss hit the ceiling.

"Sixty dollars a week!" he exclaimed. "Why I could get two women for that."

The words were hardly out of his mouth when an explosion shook the shanty in which we were sitting. Dashing outside, we saw that something had gone wrong with one of the machines; it had showered three workmen with scalding pitch. The company's woman nurse, who had also rushed to the scene, excitedly threw a bucket of water on one of the men, who was screaming with agony. His screams stopped.

The boss turned to me.

"I guess we need a male nurse," he admitted.

"You did," I corrected him. The doused patient was dead of shock.

Without wishing to sweep all the ladies off their pedestals with this illustration of one woman's incompetence, may I point out that there are nursing situations for which men are especially suited?

In long experience with men nurses, I have never seen one blow up under pressure. Man's calmer nerves and greater physical stamina give him the edge in industrial and operating-room work. His superiority in genito-urinary cases is generally recognized by the medical profession. His good influence on growing boys could be profitably utilized in pediatrics; his executive ability drawn upon to the benefit of all concerned by hospitals. In fact, I can think of few branches of nursing in which men would not be eminently satisfactory if given half a chance. A prominent medical authority once said that "the only valid reason for preferring women is difficulty in obtaining men nurses."

Today that difficulty has been large-

ly removed. Nevertheless, the greater one of conquering professional and public prejudice remains. With only 5,000 or so representatives we are numerically nursing's weaker sex.

But will this always be so? With the appointment of a men nurses' section by the A.N.A. at the last convention we have new impetus to draw men into our ranks. Surveys like that conducted recently by men in New York—showing that masculine A.N.A. members earn an average of $2,608 yearly to $1,608 for non-members—are awakening the men to their need for organization. Already New York State's men's section boasts a membership of 60 per cent of the State's men nurses; a ratio as yet unmatched by the ladies. California has followed New York in organizing a men's section. Other States can soon be expected to climb on the bandwagon.

So if you're wise, girls, you'll give us a break. If you don't, the day may come when we'll have to take it.

[R.N. *invites readers to send in their comments. Let's hear what the women have to say about the man-nurse's point-of-view!* THE EDITORS]

"Set to music—"

• In Elgin, Ill., nurses at the Sherman Hospital are singing the Florence Nightingale Pledge!

The rise of this symbol of nursing service from chant to actual lyrics should be credited to the imagination of Ella L. Rothweiler, Sherman Hospital's director of nursing education. Three years ago, the nursing school organized a student nurses' chorus. And, of course, the chorus wanted an official school song. "When our students want anything that badly," says Miss Rothweiler, "we usually try to arrange so that they can have it. So, I sat down and in my spare time dashed off a song which I called 'School Days at Sherman.' We used this for a while, but it did not prove entirely satisfactory. We wanted something with broader significance, something that would typify the spirit of the profession which our students were about to enter. Then I thought of the Nightingale Pledge."

Ella L. Rothweiler, R.N.

From the beginning it was obvious that some revision of the words of the Pledge would have to be made. "I worked at it a full year," Miss Rothweiler reports, "getting up many, many times at two or three o'clock in the morning when a rhyming word presented itself. Finally the present song materialized." Miss Rothweiler and her co-composer, Betty Van Wambeke, call it "The American Nurses' Pledge." Written in the Key of F Major, the music is impressive in its simplicity.

No novice in the writing field, Miss Rothweiler has also authored "The Art and Science of Nursing," and a series of booklet texts on ethics, charting, and psychology. "But setting the Pledge to music was the most fun," she confides.

Already Sherman students are using the song for capping and graduation exercises and in other school functions. Miss Rothweiler has copies available for sale should other schools or nursing associations be interested.

"ACUTE CONVENTIONITIS"

by Jerusha*

• "So nice," beamed my hospital's superintendent, pumping my hand in parting. "So nice you're to have this little vacation."

I must have beamed too, for I felt like something out of jail. Four whole days off to attend The Convention! For the first time in my life I was to be a full-fledged delegate and it all sounded too fearful and wonderful for words. Off I went to stay in an honest-to-goodness hotel, to live the life of the upper classes for four whole days!

As I look back on it now it seems like four months. Don't ever let anyone tell you that Biennial is a "nice restful change." It's more like Times Square on New Year's Eve, or the OBS ward in Spring. No rest for the wicked, or even for the unwicked.

But of all this I was blissfully unaware as I climbed aboard the Philadelphia train, clad in my convention-going outfit. Very professional, I looked, but with a bit of dash to the headgear.

When the train finally pulled into Philadelphia, I made two firm resolves: Allow plenty of time for sleep; try to attend every meeting . . . (!) Like an arrow to its mark straight to the Convention Hall went I, luggage and all.

The Hall was a scene of mad confusion when I pulled in just before three o'clock. Managing to register just under the line, I had no sooner attached my badge than three other recent arrivals pulled up to the booth. "Listen," said one, grabbing an inoffensive clerk by his coat collar, "You've just *got* to let us register. What's the big idea, closing this place up at this hour? We're accredited delegates. You registered *her*." (A couple of blazing eyes flashed in my direction). "What's the matter with us?"

"Uh-oh," said I to myself. "Now's the time for every new delegate to go look at the commercial exhibits." I did a disappearing act—which wasn't hard, because the exhibit area and the registration desks were as close as Siamese twins.

An hour later, laden with literature —my cocoanut straw on one side of my head—I staggered out into the street and piled onto a bus destined for my hotel.

I had made a joint reservation with the friend of a friend from another city. Economy, you know. But as several bell-hops assembled me and whisked me up to "our" room on the fifteenth floor, I couldn't help wishing that the prospective room-mate would be out. "Ah, peace and a nice warm tub," I thought. Then I opened the door to my haven of rest and found it already occupied.

Occupied is a mild word. Hatboxes, magazines, tissue paper—all over every available chair and dresser. A husky young thing, red-headed, and done up in a Roman-stripe blouse and a checked skirt, shrieked at me from the closet. "I'm McGrackle. Don't mind if I unpack do you?"

At this point the telephone rang

*Pinch-hitting for Roxann who will be on her vacation during July and August.

"The rest of the day is a wild whirl in my mind . . ."

madly. My roommate grabbed it and shouted, "Is that you Harry?" Then she looked bitterly disappointed. "It's for you."

"Hello there," came a bass voice over the phone. "This is Joe. Just found out you were in town. How about seeing you tonight? After the meeting, of course . . ."

Well, I thought, recalling my worthy resolutions, this is your "vacation." I muttered a weak "yes" into the mouthpiece.

I had just time to change from my snappy new pumps into my old oxfords when things began happening. The chairman of our committee called. "Special meeting before the banquet tonight," she cheerily reported. "You'll just have time to make it before dressing for dinner . . ."

The rest of that evening is a wild whirl in my mind. A meeting, a banquet, a meeting—sandwiched one right after the other like that, and topped off with a bull-session of delegates from back home who assembled to plan action on vital issues up for consideration the next day. At midnight I phoned Joe and told him he'd better make it some other night. I wasn't any good for what was left of that one.

When I finally dragged myself to the fifteenth floor at a teensie hour, I was met at the door with a rush of gaiety and loud laughter. "Party," gurgled my roommate. "Haven't seen some of these girls for years." How I ever got to bed that night remains hazy in my mind. I know that I did, however, because I had a dream. I dreamed of gavels pounding, and chairladies calling for motions, impatiently rasping over and over "What is your pleasure?" "What is your pleasure?" My pleasure, even in the dream, was to stay put in my trundle bed for at least twenty-four hours.

But next day I was up at dawn. I had to make a speech. It had been hanging over me for weeks and I knew it by heart. In the hectic events of the day previous, however, most of it had left me. Try as I would, I couldn't recap-

ture the singing quality of voice and the ringing quality of words with which I was blessed back home in front of my own mirror. Then, too, I was sleepy.

In the morning meeting I must have dropped off. Official business receded into the background and I was having myself a beautiful fantasy about a field full of flowers and a big black crow cawing. All of a sudden the cawing turned into a piercing voice. "We will now hear . . . (pause) . . . we will now hear . . . from . . ." This was no fancy. The next speaker was me!

A few seconds of fumbling and I was ready. "The theme of this convention has international significance," I started bravely. "Except for the urgency of sleep . . . er . . . er . . . I mean, world events—" Fortunately, it was found that the microphone hadn't been working and my reputation was saved. My constitution, however, continued to be in grave danger. But I finished the oration.

"Something nourishing to drink is what I need," I thought, descending from the auditorium to the exhibit area for a couple of quick pick-me-ups. Even without shutting my eyes it looked, smelled, and sounded like Woolworth's. Crowds of nurses were rushing about with shopping bags crammed to the top with sample drugs, sample eatables, samples and more samples. As I sat gratefully swigging some chocolate milk, a gentleman exhibitor from a nearby booth fixed me with a meaningful eye. "Haven't seen *you* before. How about a date tonight?" "This," said I coldly, "is a *nursing* convention."

Then it was time to rush long-distance over Philadelphia again for dinner at a hotel miles from mine. (Why do they always spread meeting places over as wide an area as possible?) In my anguish I went past it, rode to the end of the bus line, and started back with the driver.

"Listen lady," said he. "Aint you one of them nurses at the convention?"

"Certainly not," I replied with indignation. "I'm merely trying to establish a long-distance bus-riding record for the city of Philadelphia." With that I tripped over the last step getting out and tore my new pair of Nylon stockings.

Troubles stalked me all through my stay. On the third day McGrackle sprained her ankle and went into solitary confinement. That is, it was solitary until I got soft and broke my date with Joe so I could keep the roommate company . . .

Maybe somewhere in my career I *have* done as many things in four days, but my memory falters when I try to name 'em. When I go to a convention again, though, you can bet your last dollar there are two things I shall firmly resolve: Allow plenty of time for sleep; *don't* try to attend every meeting. Positively!

"Occupied is a mild word. Hatboxes, magazines, tissue-paper over every available chair . . ."

"EHRLICH'S *Dream*—"

A quick curb for syphilis! Is the new five-day drip treatment the answer? Here is a concise summary, prepared especially for R.N. readers.

BY ALLEN KLEIN, PHAR.D.

● The recently reported five-day treatment of early syphilis may mark the most significant advance in the battle against this dread scourge since the advent of the arsenicals. If further clincial work proves as successful as trials to date, this comparatively new method will approach Ehrlich's dream of speedy annihilation of the *Spirochaeta pallida* by short, intensive administration of a chemotherapeutic agent.

Intensive administration of arsenicals in syphilis was first successfully carried out by Dr. Goodman of New York during the First World War. Each morning, for four mornings, eighty army men were given a dose of arsphenamine intravenously. Immediate clinical gains were obtained. Uncomplicated syphilitic lesions disappeared rapidly and the men, no longer a danger to their fellows, were released from the hospital. Later, Goodman tried the intensive method in a group of women and reported similar good results.

The new five-day procedure carries this pioneer effort even further. It consists of the giving of arsenicals by intravenous route on a continuous "drip" principle. Drs. Chargin, Leifer, and Hyman, on the service of Dr. George Baehr at Mt. Sinai Hospital, New York City, have employed this method of syphilis therapy since 1933. Their first series of twenty-five patients received neoarsphenamine intermittently at the rate of 30 to 50 drops per minute over a five-day period. After observation for a period of five years, thirteen of fifteen (ten patients disappeared) could be considered cured as shown by serum tests and clinical evidence.

In another series of eighty-six patients treated in the same way, excellent results were obtained in from 83 to 91 per cent of the cases as again attested by serologic and clinical check-up. As far as could be ascertained, they were definitely taken out of the infectious class.

At this writing, some 400 patients have undergone the five-day treatment. It may be safely said that 85 per cent could be listed as cured. Manifestations of toxicity appeared in from 10 to 15 per cent of the patients—fever, cutaneous eruptions, polyneuritis, etc. One death was due to hemorrhagic encephalitis and this might have occurred with any form of arsenic administration.

Substitution of phenylarsine oxide, (better known as mapharsen), was tried in an effort to decrease untoward reactions. A definite reduction in the number and violence of toxic manifestations resulted.

The technique of the five-day treatment is fairly simple. One gram of mapharsen is dissolved in 10 litres of dextrose solution. Two drops of this solution is administered every three seconds for eight to ten hours a day. The entire 10 litres are transfused through

a "Murphy drip" into a vein on the forearm. The left and right arms are used alternately over the five days. Frequently blood analyses are made to guard against toxic reactions.

The bloodstream becomes what might be called "highly saturated" with the drug, three parts per million in the last days of treatment. With this method the system appears to build up resistance to "shock" against quantities of the arsenical which is given in much greater dosage than employed for the standard divided dosage technique. Thus far, no bismuth, iodides, or other accessory chemicals have been utilized in conjunction with the arsenicals. The investigators wished to test the procedure in its simplest form and they desired the arsenical to stand alone.

It must be emphasized that authorities do not, at the present stage of experimentation, suggest that the average private practitioner try the five-day treatment. They recommend that it be confined to the hospital under careful supervision, with highly qualified nurses at hand. Arrangements are being made for more extensive trials of the method in various institutions throughout the country. A number of refinements will be tried, perhaps several new arsenicals or combinations of arsenicals. Undoubtedly auxiliary drugs will be employed. In this connection it might be noted that Dr. W. M. Simpson of the Miami Valley Hospital, in Dayton, Ohio, reports that artificial fever often fortifies the curative action of the arsenicals. The number of days of treatment may be shortened or lengthened. In short, the five-day treatment is still very much in the experimental stages.

Thus far, too, most of the cases have been early syphilis in males. Will the treatment be effective in latent syphilis, syphilis in women, congenital syphilis, other forms?

Only time and trial will tell. However, should it be effective solely in early syphilis, the gains against spread of the disease will be enormous. This is easily recognized when one considers that were a considerable number of the annual 600,000 new cases taken out of the communicable class there would be a decided [*Continued on page* 30]

Family tradition

● In 1960 some enterprising member of the R.N. staff will look up this group picture, pair it with a similar one for the current year, and call the result "Three generations of registered nurses." For the Waller family has decided that three nurses in 1940 are not enough; they're going right on producing nurses in the generations to come. Grace Waller (standing), is head of the family and nurse-anesthetist at Bloomsburg Hospital, Bloomsburg, Pa. Her youngest daughter, Dixie Bee (left), just graduated from St. Joseph's Hospital in Bloomington, Ill. Eldest daughter, alumna of Bloomsburg's Mennonite T.S., is now Mrs. Clarence Myers (right). Baby Joan Myers is already prepared to follow in mother's footsteps.

In review

A QUICK GUIDE TO CURRENT BOOKS OF INTEREST TO NURSES

MATERIA MEDICA, PHARMACOLOGY, AND THERAPEUTICS.

By Maude B. Muse, R.N., A.M. $2.75. *W. B. Saunders Co.* (*Second edition.*)

● Here is a comprehensive and up-to-the-minute summary of drugs and other therapeutic agents and their uses in the treatment of disease. Excellent as a practical teaching text, this new edition should also serve as a guide to the newer drugs (dilaudid, dinitrophenol, decolin, lextron, extralin, haliver oil with viosterol, antivenin, arbutin) and other therapeutic aids, such as serums, vaccines, vitamins, hormones, physical and mental therapy.

The new second edition contains two entirely new chapters: "Remedies Used on the Skin, Mucous Membranes, and Wounds"; and "Tissue Antiseptics and the Arithmetic of Solutions." The book conforms to the New U.S. Pharmacopeia and the New National Formulary.

LET'S TALK ABOUT YOUR BABY.

By H. Kent Tenney, Jr., M.D., F.A.A.P. $1.00. *University of Minnesota Press.*

● Here's a book with the homey tone of the family physician chatting with the new mama and papa. Dr. Tenney believes care of a baby should be a constant source of enjoyment. He's against "slavish adherence to a routine" when it interferes with the individuality of either baby or parents. New mothers will like his book because it manages to offer expert medical guidance without setting up too many scientific barriers.

In the back of this pleasantly pink-and-blue volume, there is a section called "Important Events in the Early Life of....." Mothers can insert here baby's first snapshot, birth records, daily weight for six months, date of first tooth, first step, and other vital statistics.

Conscientious nurses who want to recommend such a book to their patients will be glad to know that Dr. Tenney is associate professor of pediatrics at the University of Wisconsin and associate pediatrician to the State of Wisconsin General Hospital. And when it comes to questions of diet, clothing, training, and protection against disease, he seems to be expertly informed. The book covers baby's progress from birth to approximately 15 months.

AMERICAN POCKET MEDICAL DICTIONARY.

Edited by W. A. Newman Dorland, A.M., M.D., $3.00. *W. B. Saunders Co.* (*Sixteenth edition.*)

● When you read about new drugs and treatments, do you often wonder how to pronounce some of the new names scientists are continually thinking up?

This handy little volume measures 4"x 6½" and contains concise definitions and phonetic pronunciations of a complete medical-nursing vocabulary. Appended are sixty tables, including one of professionally correct abbreviations for commonly used medical terms.

SO YOU'RE PUBLICITY CHAIRMAN.

By Frances Fiske. $2.00. *Whittlesey House.*

● Don't be panicky if your district has just appointed you publicity chairman for the Fall and Winter season. Getting a break in the papers can be boiled down to a technique as simple as taking a temperature. And Mrs. Fiske's book tells you, in simple terms, how to do it.

Written chiefly for women's clubs in medium-sized communities, this book is not the gateway to the front pages of large metropolitan dailies or to national magazines and radio. Its sound advice and basic publicity [*Continued on page* 32]

The QUESTION of DUES

• A nurse from Texas, up North to visit the Fair, came in to see us the other day with a clipping which, she said, made her "hoppin' mad." It was an item from the A.N.A.'s bulletin "Professional Nursing." Here's what it said:

> The A.N.A. Board's recommendation to increase the annual dues of the A.N.A. from fifty cents to seventy-five cents was defeated by sixty votes. [At the Biennial.] An electrician behind the scenes who heard the discussion from the floor wanted to know if the twenty-five cent recommended increase was per day, per week, or per month. When told it was per year, he shook his head in incredulity. "They're not fussing over twenty-five cents a year?" he exclaimed. "Why, I have to pay $10 just to get a tire changed down here!" He went off repeating unbelievingly, "Twenty-five cents!!"

That kind of anecdote is bound to make somebody "hoppin' mad." What was probably just a funny story to its instigator becomes, in the eyes of those who opposed the increase, a slap at their intelligence. Even to impartial observers it lacks humor, suggests unnecessary bitterness, and fails to get right down to the basic issue.

The basic issue in this case was the fact that membership money coming to the A.N.A. each year is not sufficient to carry its overhead. For the two years ending in December 1939, the association had a deficit of $17,556. Obviously, no organization can maintain a constructive program *in the interest of individual members* when its annual income is too small to pay its way.

From this standpoint we believe the A.N.A. was justified in proposing the dues increase. We hope the delegates who voted "no" did so with full understanding that need, not greed, prompted the proposal.

At the same time, we think a little more understanding is in order on the part of those who favored the increase. Delegates who were responsible for its defeat were not "fussing" over a quarter a year. They were not stubbornly going out of their way to create hardships for the staff at national headquarters. They were simply—and forcefully—sticking by their convictions.

The dues increase was defeated because the majority of States need funds locally just as much, proportionately, as does the national association. So long as the real burden of administering professional nursing activities continues to rest with district and State groups, the difficulty of raising more money for national expenses will continue. It is human nature to give more readily to that which touches the individual closest.

This need not create a dilemma for the A.N.A. Paring down of all but essential expenses during the next two years should demonstrate to the membership at large a conscientious effort toward economy. And substitution of active program for research should bring headquarters closer to individuals. In return, it is to be hoped that the membership will not get "hoppin' mad," that it will support the association's request for increased dues when that topic arises—as it inevitably must—at the next Biennial.

Globe

Research and scientific canning methods guard consumers against possible spoilage in commercially offered foods.

QUICK FACTS ABOUT

Food

• **Spoilage and contamination.**— Food spoilage and contamination have been serious problems since time immemorial. In the Middle Ages, before refrigeration, various methods were tried to preserve the palatability of food. It is said that spices and condiments owe their origin to their ability to mask the unpleasant odors of putrefaction and decay. Many epidemics were undoubtedly due to transmission of pathogenic micro-organisms by food spoilage and unhygienic handling of food.

In its broader sense, food poisoning implies the production of disease by any pathogenic organism which may be consumed with food. However, with our increasing knowledge of bacteriology and epidemiology, the term food poisoning takes on a more restricted meaning. It is known, for example, that amebiasis, trichinosis, dysentery, tenia infestation, cholera, tuberculosis, typhoid fever, and a host of other infections may be transmitted by food which contains the appropriate organisms. But these are merely examples of food contamination; food is by no means essential for transmission, since the organisms can reach the human host via many other routes. Food poisoning, on the other hand, now signifies the production of disease by living bacteria which actually infect food and which can find their way to man by few other routes. Food poisoning may also be due to toxins from *Bacillus botulinus*, or the toxins of mushrooms, milk, fish, or grain.

Food spoilage by putrefaction is not regarded as a cause of food poisoning. Most authorities believe that it is not a frequent factor in the production of disease. Food spoilage usually produces unpleasant odors which come from certain decomposition products. While all "spoiled" food is probably not injurious, the disagreeable stench which arises therefrom forcibly warns the prospective eater, and the food is usually discarded. Certain primitive tribes consider "spoiled" meat and entrails as delicacies and apparently thrive on them. The older idea of ptomaine poisoning was based on the erroneous premise that the products of food decomposition, or ptomaines, are poisonous. The designation "ptomaine poisoning" should be discarded, since its use frequently obscures the true nature of the infection under consideration.

Causative micro-organisms.— True food poisoning is usually due to one of three micro-organisms, all of which are members of the so-called Salmonella group of bacilli—*B. enteritidis* (Gaertner's bacillus), *B. aertrycke*, and *B. suipestifer*. While most frequent-

poisoning

ly found in meat, these bacilli may be transmitted by any type of food, particularly dairy products. They are usually alive when ingested. Some controversy exists as to whether they elaborate a true toxin.

The source of the causative microorganisms is a matter of conjecture in any given case of food poisoning. It is important to remember that food may be unchanged in appearance, taste, and odor, and yet be the cause of serious gastrointestinal disturbances.

The only exception to this statement is in the case of food containing the organism of botulism. Here a sour, spoiled butter-like odor is detected. Frank putrefaction is no indication of infestation with the members of the Salmonella group of bacilli.

It is generally believed that food becomes infested by flies, mice, and rats. The Salmonella organisms are commonly found in the intestines of rodents. Fecal contamination readily takes place either directly from contact with food by rats or indirectly through transmission by flies.

Implantation of the organisms occurs after cooking, since the heat of boiling or baking is usually sufficient to destroy bacilli. Hence, adequate protection of cooked foods is necessary for the prevention of bacterial implantation. Food poisoning is seen most frequently during the summer months when rapid multiplication of the organisms is facilitated. The need for dependable refrigeration when food is stored is obvious.

International

Mushrooms are most frequent cause of food poisoning. Doctors advise purchase of only those known to be cultivated.

Symptoms and etiology.—The onset of food poisoning is sudden, occurring three to twelve hours after ingestion of tainted food. Nausea, vomiting, abdominal cramps and diarrhea are prominent features. Weakness and collapse may develop if the loss of fluids is not checked and if the intoxication is not promptly overcome. The temperature is elevated but slightly.

The history is of significance only if a number of people are known to become afflicted at the same time. Most patients who develop food poisoning are prone to regard one food or another as etiologically related to their illness, but such incrimination is usually not reliable since unpalatable or unattractively prepared foods may erroneously be held responsible. If a number of persons attending a banquet or picnic become ill, or if a group of customers patronizing one food store develop an acute abdominal disturbance, the probability of food poisoning is strengthened. Not only meat, but milk, cheese, cream puffs, and related foods may be contaminated.

Treatment.—The treatment of food

poisoning aims to remove the responsible organisms and their toxins from the intestinal tract, and to counteract their irritating influence. The stomach is promptly emptied either by stomach tube or emetics. If the former is employed, gastric lavage with warm saline solution or a solution of sodium bicarbonate is desirable. Epsom salts or castor oil is given to insure disposal of the causative organisms. Through the use of kaolin, bismuth subnitrate, and apple pectin, the inflamed bowel wall is soothed and the bowel movements reduced in frequency. If these measures do not overcome the abdominal cramps and stop the diarrhea, tincture of opium or morphine sulfate is administered. If the fluid loss has been great, saline or dextrose solution can be given by venoclysis, especially if nausea is marked. Bulky or coarse foods are withheld for several days after recovery in order to prevent a recurrence.

Specific forms: Botulism.—Fortunately not common in the United States, botulism is the most deadly form of food poisoning. It is due to *B. botu-*

Milkman

The story of a man who is an authority on a woman's topic—nursing bottles.

• Before 1931, Dr. David Overton of Hempstead, N.Y. had only the average pediatrician's knowledge of nursing bottles. But that year marked the beginning of his over-weening, so to speak, interest in Early American child-feeding devices. Today he is an authority on the subject; perhaps the only one.

It began when he saw a picture of a pewter pap spoon. He besieged editors, museums, and collectors until he found a man named Kerfoot who owned one Kerfoot also had two French 18th-century nursing bottles. "The moment I spied them," the doctor says, "I was off."

Since then he has virtually bought out the market. Now the only way he can obtain pieces is to lure them from collectors. This has its lighter side. Once the doctor stumbled upon what its maiden-lady owner described as a Colonial inkwell. Actually, it was a glass device once worn on nipples between nursings. Told the truth, the lady was so embarrassed she told him to take it away.

Today the doctor's collection totals seventy-five pieces and is considered the finest in private hands. Practically every period in American life is represented. The earliest items are of 500-

linus, a spore-forming organism found in soil. The spores find their way to a large variety of fruits and vegetables, and may be present in the intestinal tract of cattle.

Virtually all foods can become contaminated by this bacillus—meat, fowl, seafood, fruit, vegetables, and dairy products. Home-canned foods, especially those prepared without the aid of a pressure cooker, may contain the organism because of improper sterilization during the process of canning.

Foods containing *B. botulinus* can be recognized by a characteristic rancid butter odor, although they may be unchanged in all other respects. Questionable foodstuffs should not be tasted. Because of the great potency of the toxin, tasting may cause death. All cans which bulge on their sides, or cans from which gas escapes when opened, should be promptly discarded without further examination. The toxin of *B. botulinus* is destroyed by a short period of boiling, but since many canned foods are not heated before being eaten, the toxin is not destroyed. [*Turn the page*]

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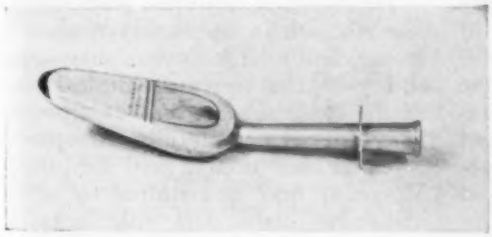
year-old pottery from prehistoric Indian graves. They were never filled with animal milk, Dr. Overton explains, but with ground nuts mixed with water.

Other examples are tin cans used by the Pennsylvania Dutch; a "scrimshawntner" nipple carved by a New Hampshire whaler; a "bottle" made from a cow's horn; and even some of Staffordshire ware and Stiegel glass.

In some frontier sections even today, Dr. Overton declares, babies are fed from hollow cows' horns. Their adaptation is simplicity itself: First, the tip of the horn is snipped off. Then, a piece of chamois or a glove finger or a tanned cow's teat is tied on to do duty as a nipple (the one illustrated is a bit less rudimentary).

A century ago, the doctor says, mother often employed a cylindrical tin feeder. On one side was a spout; on the other, a tin nipple. Still another novel device once used was a milk container with a tin saucer. To warm the milk, the mother merely placed some inflammable liquid in the saucer and lighted it.

The Overton collection includes bottles and feeders. [*Continued on page* 41]



Pap, in the old days, tasted no better in this pewter pap spoon. Mama puffed through the tube-handle when baby needed encouragement to eat.

A cow with a crumpled horn provided this "bottle." Similar feeding devices are said to be still in use in frontier sections today.

Unlike food poisoning due to Gaertner's bacillus, botulism is not predominately a gastrointestinal disturbance, but rather a fulminating toxemia. A variable but mild degree of nausea, vomiting, and diarrhea may develop in one or two days following the ingestion of contaminated food. Thereafter, in rapid succession appear weakness, lassitude, dizziness, visual disturbances (blindness at times), dryness of the throat with a sense of constriction, marked constipation, and at times paralysis. The temperature is not elevated. Death occurs in a few days from respiratory paralysis or cardiac failure.

Treatment, in order to be successful, must be instituted early. An antitoxin is available which produces good results if given within the first twenty-four hours. When the patient is first seen, the stomach is emptied and a potent cathartic (such as croton oil) is administered to rid the intestinal tract of the toxin.

In the nursing care of botulism, care must be taken to avoid moving the patient, since fatigue brings about muscular twitching. The pharynx becomes the seat of mucous accumulations which should be removed frequently. The patient should not be fed if pharyngeal paralysis supervenes, because of the danger of aspiration and the possibility of pneumonia. The administration of fluids and glucose by vein aids in preventing dehydration and maintains the nutritional state. The rate of respiration should be carefully observed, and the first indication of respiratory paralysis or cyanosis must be reported at once.

It is believed that the use of oxygen or an artificial respirator is of value in respiratory embarrassment. Recovery, if it occurs, takes place within one week, but the convalescent period is prolonged.

Mushroom poisoning.—Intoxication from poisonous mushrooms is an example of true toxic poisoning by a food. Many varieties of poisonous fungi have been described, but their detection by a layman is virtually impossible. The common practice of cooking the mushroom in a silver spoon is not reliable. The taste of the dangerous varieties does not differ from the nontoxic forms, and in fact may be more appealing. The safest course is either not to eat mushrooms at all, or to purchase cultured mushrooms which have been grown under controlled conditions. Under no circumstances should "wild" mushrooms be eaten.

There are four major groups of poisonous fungi, each of which produces a violent toxemia. The common toadstool is the most frequent offender. In general, poisonous mushrooms are brightly colored and present a scaly surface.

The symptoms of mushroom poisoning appear precipitously and gain rapidly in severity. Intense nausea and vomiting are followed by marked diarrhea. The stools are watery and contain blood and undigested food particles. Salivation, lacrimation, and perspiration are profuse. In some patients, jaundice is seen. Contraction of the pupils is a frequent sign and is pathognomonic if present. Convulsions followed by death is the rule in a high percentage of patients.

Treatment is instituted immediately. The stomach is thoroughly washed by lavage, and a large dose of magnesium sulfate is given to remove the last traces of the toxin. Fluids and dextrose are administered parenterally. Atropine is given in full dosage and frequently. Morphine may be required to control abdominal pain, and stimulants are usually needed to prevent or counteract collapse. Kaolin is administered by mouth to adsorb the vegetable toxin. In spite of intensive therapy, however, the mortality rate in mushroom poisoning is high.

Prevention of food poisoning.—From the foregoing account, it is clear that the threat [*Continued on page* 41]

NUTRITION Briefs

● A lot of funny stories have been written about molasses. There is the classic about the pickaninny who, when asked if he'd have some, replied, "How can I have mo' 'lasses when I ain't had no 'lasses at

all!" A host of other anecdotes have fixed molasses in the minds of most of us as the partner of sulphur in grandma's favorite remedy for Spring fever.

Now it appears that those of us who have classed this product only as a liquid which moves slowly in January, are in for an educational jolt. Molasses comes into its own and is hailed as a rich source of available iron. It compares favorably with beef liver and tops eggs, raisins, and spinach by a respectable margin.

Recent research at a leading Eastern college indicates that Brer Rabbit brand New Orleans molasses, made from Louisiana sugar cane, contains six milligrams of iron to every 100 grams of molasses. Over five milligrams of the six are available for use by the body. This record is second only to the iron content of beef liver, which has eight milligrams of iron to 100 grams of beef liver. Only about five and a half milligrams of this beef-liver iron are available. In a hundred grams of egg, only three milligrams of iron are available. And in that loudly promoted builder-upper, spinach, less than half a milligram of usable iron is found per 100 grams of greenstuff.

Cooked or uncooked, molasses has the same high iron content. Its particular value is that it is not expensive and can be used in unlimited quantities on low-cost diets.—*Am. Jour. Digestive Dis., 1939.*

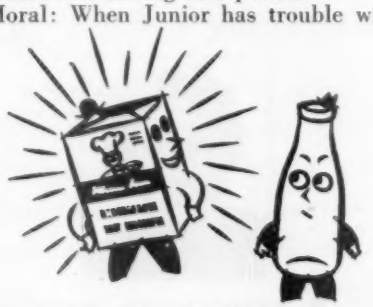
● Another staple of the kitchen cupboard turns up this month, endowed with added nutritional glamor. Cream of Wheat, out in a new five-minute form, is declared by research men to supply 100 milligrams of calcium and 118 milligrams of phosphorous to the average serving.

As a source of both these minerals, fortified Cream of Wheat is as good as, and under certain conditions better than milk, according to the recent figures from a University of Vermont study.

Ten pre-school children—six boys and four girls—served as subjects for the tests, ate a colossal amount of Cream of Wheat over a total period of twenty-three weeks. During five weeks, part of the milk was removed from their diets and replaced by enough New Cream of Wheat to give equivalent amounts of calcium and phosphorous. The rest of the time, the children ate old-style Cream of Wheat.

During the five weeks under New Cream of Wheat, calcium was better retained than at any other time in the study. Phosphorous also showed a higher retention score during this period.

Moral: When Junior has trouble with



milk consumption, fortified Cream of Wheat, it would seem, could understudy with good results.—*Pierce, Daggs, Meservey and Simcox: The Retention of Calcium and Phosphorous by Pre-School Children. Jour. of Nutrition. April 1940.*

A fairly new air-conditioned maternity hospital in northern California, very well-equipped, is in need of two obstetrical nurses—one for bedside nursing and the other for delivery room service. Eight-hour day; six-day week. A grand place to work.

Between now and the first of the year the anesthetists comprising the staff of the anesthesia department in an eastern hospital (there are three of them) will marry. The one who will report August 1 should be thoroughly experienced, as she would probably be the senior anesthetist. The two others would be expected to report in October and January. The physicians and surgeons are extremely nice to work with; the atmosphere of the hospital is not at a tension.

Calling ALL NURSES

Is there someone in the profession you'd like to locate? You may insert here, without charge, a 75-word notice. Items will be published in the order received. Be sure to include your full name and address so that replies may reach you. Address the "Calling all nurses" editor.

ALL NURSES: My hobby is collecting stamps, old and new, from the United States and foreign countries. All contributions will be gratefully received and acknowledged. Lillian Dunlap, East Moriches, N.Y.

LOU ARNOLD: (Graduate of Holy Cross Hospital, Calgary, Canada.) I would so love to hear from you. Remember Rockcliffe Park, Ottawa, and "King's Daughters"? Dot. (Mrs.) L. D. Hook, Friday Harbour, Wash.

HAMOT GRADUATES: (Erie, Pa.) We are planning a reunion on August 17th to celebrate the fiftieth anniversary of the training school. Would like information on: Margaret McCarthy, Marian Thompson, Stella Walters, Minnie Kennedy, Christina O'Conner, Grace Blake, Esther Petersen, Kathleen Batty, Ruth L. Magness, Jennie Steinbaugh, Dorothy Gould Rowe. Girls, please write to Arvilla O. Hill, 1330 W. 11th St., Erie, Pa.

LUTHERAN GRADUATES: (Hampton, Ia.) The hospital will observe its twenty-fifth anniversary September 20th, at which time a reunion of nurse graduates will be held. We hope you will all want to attend. In any case, please write and tell us what you are doing. Martha E. Hein, Hampton, Ia.

ST. JOSEPH'S ALUMNAE: (Hancock, Mich.) Will all members please get in touch with the secretary so that we may

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revise our mailing list? There are several members we are not able to locate. This is important as we are planning a homecoming. Ruth A. Driscoll, 624 Lake Ave., Hancock, Mich.

EDNA LESSINGER McLAUGHLIN: (Michael Reese, '22.) I've been so disappointed since I haven't heard from you. Won't you write soon? Olive Harris Carlson, 7557 Clyde Ave., Chicago, Ill.

"Ehrlich's dream—"

[*Continued from page* 18]

reduction in the number of new cases.

With the period of treatment shortened from an average of eighteen months to five days, more patients would be willing to undergo treatment. This would also be true insofar as financially disabled patients are concerned as it has been estimated that the standard series of arsenical injections cost about $300 as against the $82 cost entailed by the intravenous drip method.

Less discomfort in treatment, less time lost from work, and other advantages would result if the five-day method could be made universal. Not alone the patients but the general public would benefit. Certainly the five-day method has vast possibilities.

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In review

[*Continued from page* 19]

philosophy, however, may well be adopted by local nursing groups. The author's style is breezy and punctuated by entertaining little line drawings.

MANUAL OF PUBLIC HEALTH NURSING.

Prepared by The National Organization for Public Health Nursing. $2.50. *The Macmillan Co.* (*Third edition.*)

● Annual guide to standards for public-health nursing is this excellent handbook which, the N.O.P.H.N. states, was designed "to meet the needs of the staff nurse and the nurse working alone."

Of real significance is the new chapter on orthopedic nursing and the expanded discussions of venereal disease control, industrial nursing, and tuberculosis. Nurses in out-of-the-way communities who wish to set up nursing services in industry will find this chapter excellent. Throughout the book, the nursing techniques recommended are based on fundamental principles which may be applied to homes, clinics, schools, or industrial plants.

PSYCHIATRY FOR NURSES.

By Louis J. Karnosh, M.D., *and Edith B. Gage,* R.N. $2.75. *The C. V. Mosby Co.*

● The authors of this text should win the plaudits of psychiatric instructors and, particularly, their students. The book handles a cumbersome topic authoritatively and yet holds the reader's interest throughout. That is a new high in nursing texts!

The whole gamut of mental disorders are herein admirably discussed and illustrated with terse clinical examples. Beginning logically with a historical review of psychiatry, this text strides easily through twenty-nine chapters and 317 pages. Among the broad and specific topics included are heredity and mental disease, the structure of personality and its defense mechanisms, the causes and classification of mental diseases, management and observation of mental patients, a variety of reaction types, physical therapy, occupational and recreational therapy, and shock therapy in mental disease. Whole chapters on these latter therapies make a

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notable contribution to the field of psychiatric nursing.

Instructors should be delighted to find herein a minimum of difficult scientific terminology. Definitions of psychotic types are expressed concisely and simply. Each chapter includes a list of references and questions based on foregoing content. The book is well-indexed and its table of contents is broken down into detailed subject headings.

Both authors are affiliated with the neuropsychiatric division of City Hospital in Cleveland, Miss Gage as supervisor. Dr. Karnosh is also associate clinical professor of nervous diseases at Western Reserve's school of medicine in Cleveland.

BANDAGING AND FIRST AID.

By Lois Oakes, S.R.N., $2.00. *Williams and Wilkins Co.*

● In this era of bombs and blitzkriegs, knowledge of first-aid may be the means of saving lives.

Miss Oakes' handbook is brief and practical, simple enough to offer the layman but containing new tricks in bandaging which should please professional nurses. The author recommends the emergency triangular bandage of muslin for all ordinary purposes. She also includes chapters on roller bandages, first-aid for hemorrhage and fractures. The book is excellently illustrated with photographs by J. N. Queensborough.

The author is editor of London's *Nursing Illustrated,* a weekly magazine for nurses, and is examiner to the British General Nursing Council.

Below the equator

[*Continued from page* 10]

the "sick poor" and insist upon being nursed in their own homes—by *foreigners.* As money is no object, they pay high salaries.

Oddly enough, private nursing was an unexplored field in South America until recently. One reason may be that it takes considerable courage and capital—$1,000 is a minimum. A group of

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British nurses recently demonstrated that it is practicable in Buenos Aires, at least. Their reward has been a monopoly on fashionable Argentinean patients.

For the average nurse, however, the best situations are those with American industrial firms. Here living conditions and salaries are equal or superior to those at home. For general duty, she receives about $135 a month ($120 on the Caribbean), which may or may not amount to more than she would earn in the States, depending upon local living costs. In an executive position, her maintenance may include a servant. She usually has access to golf, music, movies, swimming, and other amusements. It is customary for her to be invited to join the local country club. And if, by chance, she is looking for a husband, there is no better place to find one than in these oil fields, mines, and plantations. One registry boasts that of all the nurses it has placed with such firms, only two failed to marry within two years.

In looking for a South American job, you can't afford to be too choosey. There is a surplus of aspirants. Many of the positions are awarded to relatives or friends of officials. Lacking this, your next best bet is a reliable employment agency.

Nearly all the better registries report a small but steady stream of such openings. Most of them charge a $2 fee to be registered—plus 5 per cent of your first year's salary when they find you a position.

Requirements are fairly stiff. Legally, anyone with an American R.N. can nurse in South America. But to this employers have added a number of other qualifications. Almost all stipulate that candidates be single and between 25 and 35 years old. They strongly prefer girls with a "working knowledge" of Spanish, operating-room and O.B. training, personality and resourcefulness. If you have had experience as an anes-

thetist or technician, you are in luck. There is demand for these services at $150 and $125 a month respectively, plus maintenance.

Once you are accepted, you will be offered a contract—usually for two years. The first thing *not* to do is sign it in haste; otherwise you're likely to repent at leisure. Read it through until you understand every clause. Better, have a lawyer friend go over it. Three points to check carefully are: compensation, location, and transportation.

On paper, South American salaries almost invariably sound big. A promise of 800 pesos a month for general duty in Chile put a friend of mine in seventh heaven. Then she discovered that a Chilean peso, despite the dollar sign in front of it, was worth about four cents. Have your employment counselor inquire into mode of payment for you. Payment in specie may substantially reduce your income's exchange value. It might mean that you would have difficulty meeting your insurance premiums, or that you would be unable to save as much as you should. On the other hand, it may not affect your local *purchasing power* at all.

Another matter worth examination is your location. The best-intentioned employment agencies may not be equipped to advise you accurately on this. I recall the case of a nurse who took a job in a hospital—"right on the seashore." Or so the registry described it. When the boat docked, she looked around for the glittering palace of mercy her imagination had erected on the sands.

"The hospital?" echoed the company agent who met her. "Oh, it's inland a bit. Just 196 miles!"

After several days of travel by auto, train, canoe, and muleback, this innocent abroad finally reached her destination—an insect-infested shack in a shadowy swampland.

South America is not all a land of eternal sunshine. Its climate is surpris-

ingly variable. On the Peruvian West Coast, the saying is that it rains once every hundred years; a few miles away, up in the Andes, are perpetual snow and ice. Parts of the continent are barren deserts; others are impenetrable forests.

So don't invest in smart tropical outfits only to discover on arrival that what you need is warm tweeds! And be sure to take along sufficient stockings, shoes, underwear, and uniforms for the length of your stay. South Americans have an idea that only the wealthy wear silk; they tax it unmercifully. Satisfactory shoes and uniforms are almost unprocurable in certain regions.

Finally, scan with a sharp eye the provisions your contract makes for transportation. Insist upon *first-class* passage *both* ways. It's a privilege that no reputable employer will deny you. Besides this, he should be responsible for all arrangements regarding visas, although you may properly be expected to provide your own passport.

Some contracts insist upon a cash guarantee of your stability. That is, the cost of your passage is deducted from your salary in monthly installments; then returned to you in a lump sum at the end of the year. Should you leave before then, it is forfeited. Others deny you passage home if you break the contract.

Against this eventuality, it's wise to have a cash reserve of at least $200. While the American consul may loan you boat fare, he doesn't have to. He does such favors out of the goodness of his heart—and pocket—and is sometimes not repaid.

After reading this, you may decide that South America is not the paradise it has been painted. Certainly several years' residence there convinced me that nursing below the equator is not all wine and *frijoles*. In the long run, you may wonder, is it a worthwhile experience? My answer is that, as this is written, I'm again rolling down to Rio.

Food poisoning

[*Continued from page* 26]

of food poisoning is a real one, and must be guarded against at all times. Careful selection of food and eating establishments is essential.

Suspected foods should be discarded *without being tasted*. Thorough boiling of food and water for ten minutes destroys toxins and bacteria and minimizes the danger of intoxication. When traveling in foreign lands or in communities where facilities for refrigeration are limited and public-health control is poor, utmost caution should be maintained at all times. If such conditions are anticipated, a supply of concentrated foods which do not spoil easily should be provided for emergencies.

[*For a bibliography of the procedures discussed in this article, send a stamped, addressed envelope.*—THE EDITORS]

Milkman

[*Continued from page* 25]

in an astonishing variety of shapes. Some are fashioned to look like soldiers; others like crying children.

The pewter pap spoon, also illustrated, is 150 years old. If the feeding did not progress quickly enough, the mother blew through the hollow handle to speed up the process.

Dr. Overton traces nursing-bottle history to the Stone Age. One of his ancestors, he has discovered, produced glass in Salem, Mass. in 1639. So far it has not been determined if he made nursing bottles; his specialty being rum flasks. Dr. Overton would like to locate the bottles—if any—from which the infant, George Washington and Abraham Lincoln obtained nutriment. He does not consider American history complete without them.

His researches have brought him

chairmanship of his county medical society's milk commission and an invitation to lecture on his bottles at Yale Medical School. They have also inspired his theories as to the nursing bottle's future. One is that it may some day be quartz, to let in ultra-violet rays.

Dr. Overton keeps his bottles in his office. Curious mothers often ask an explanation, creating an opportunity to discuss their children's diets. He confesses a temptation to see if his antiques would work with modern youngsters, but so far has resisted it. Besides, he is afraid the milk might damage his bottles. His two children were nursed on bottles, though modern ones. Milk as might be expected, is his favorite drink.—*Courtesy of* MEDICAL ECONOMICS.

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LAXATIVE: To correct chronic constipation, doctors frequently suggest TAXOL because extensive clinical studies have shown it to be an effective remedy. Mild and harmless, this product is said to be especially valuable where cathartics and purgatives are contra-indicated. If your patient suffers from intestinal stasis, ask your physician whether Taxol may be recommended. For your own trial, address Lobica, Inc., Dept. RN 7-40, 1841 Broadway, New York, N.Y.

TAMPAX: This modern internal absorbent, designed by a physician, is now available in three sizes to meet every individual need for menstrual protection. *Super Tampax*, especially indicated for the woman with profuse discharge, or for those days when extra protection may be desired. *Regular Tampax*, for the average woman with a normal flow, for whom it usually serves during the entire period. *Junior Tampax*, designed for the younger woman, or for use during the waning days. For samples, write Dept. RN 7-40, Tampax, Inc., New Brunswick, N.J.

VACATION: It's not too late to be thinking about yours. Nurses proverbially have to plan vacations to fit busy schedules. If your "time off" comes between now and the first of the year, now is the time to start a little research for travel bargains. Are you headed for California, Mexico, the Deep South, or Lake Louise? HAPPINESS TOURS has planned a series of all-expense trips starting as low as $35. For free folders (be sure to specify your destination), write to Happiness Tours, Dept. RN 7-40, 39 S. State St., Chicago, Ill.

FOOT AID: July and August are hard on nurses' feet. Summer heat, rubber-soled shoes, and constant pounding on hard hospital floors cause burning, itching, and general foot-fatigue. When you come off duty, here's how to get quick relief: Plunge your feet into a tub of warm water in which you have dissolved a packet of JOHNSON'S FOOT SOAP. The soothing medications blended into this product scotch aches and soreness in record time. Also said to be good for corns and callouses. For free sample write Russell Provost, Dept. RN 7-40, Thomas Gill Soap Co., 711 Kent Ave., Brooklyn, N.Y.

PRE-SHRUNK UNIFORMS: Sanforized (pre-shrunk) poplin uniforms are easy on the budget because they last longer than fabrics not made to stand hospital laundering. WHITE ROCK uniforms come in a variety of long and short-sleeved styles, all featuring the season's newest fashion touches. One particularly effective model uses tucks in an interesting sunburst effect on the front. Prices on the entire line are below $3. For catalog and swatch of material address Miss Dorothy Goding, Dept. RN 7-40, White Rock Uniform Co., Lynchburg, Va.

SKIN TREATMENT: Eczema, psoriasis, ringworm, athlete's foot, and other skin disorders have been effectively treated by MAZON ointment. It is non-greasy and non-staining, and requires no bandaging. A special soap is also available to prepare the skin for application. Samples of both soap and ointment obtainable from Belmont Laboratories, Inc., Dept. RN 7-40, 4430 Chestnut St., Philadelphia, Pa.

Positions available

To apply for a "position available," simply outline your qualifications in a letter. Address it to the correct box number care of R.N.—A JOURNAL FOR NURSES, *Rutherford, N.J. All positions are listed by a placement bureau except those otherwise indicated. (Send no money with your application. If the bureau requires a registration fee, it will bill you separately.)*

ANESTHETISTS: Three openings on staff of fairly large hospital. Duties not arduous. Appointments August, October, and January. (Placement bureau charges $2 registration fee.) Box MB7-11.

ANESTHETIST: South. Mature, experienced woman of good character sought to head anesthesia department of large southern hospital. Salary, $125; full maintenance. (Placement bureau charges $2 registration fee.) Box C153.

ASSISTANT DIRECTOR OF NURSES: Experience in university school of nursing required for assistant directorship in university hospital. Appointment carries rank of associate professor; duties include responsibility for educational program. Salary, $175; complete maintenance. (Placement bureau charges $2 registration fee.) Box MB7-3.

ASSISTANT DIRECTOR OF NURSES: Midwest. Large general hospital has September opening for qualified woman with college credits. Degree not required. Salary, $125; maintenance. (Placement bureau charges $2 registration fee.) Box MB7-6.

DIETITIAN: Opening for chief dietitian in large psychiatric institution. Three years' State hospital experience required. Salary, $130; maintenance. (Placement bureau charges $2 registration fee.) Box MB7-28.

DIRECTOR OF NURSES: Midwest. New hospital seeks college woman experienced with all-graduate staff. Salary, $125; maintenance to start. (Placement bureau charges $2 registration fee.) Box C157.

DIRECTOR OF NURSES: Midwest. Opportunity for thoroughly experienced nurse-executive with college degree; 250-bed general hospital, State capitol. Salary, about $225; maintenance. (Placement bureau charges $2 registration fee). Box MB7-4.

DIRECTOR, O.P.D.: California. Large out-patient department, averaging 200 patients daily, seeks graduate nurse with college degree and P.G. training in public health. Two years' previous out-patient experience in position of responsibility required. Salary, $175; partial maintenance; 44-hour week. (Placement bureau charges $2 registration fee.) Box MB7-10.

EXECUTIVE SECRETARY: Well-organized county tuberculosis society seeks college graduate with major in social sciences or health education. Must own automobile. Headquarters to be in city of about 100,000 population. Salary, $1,800 first year; liberal increases. (Placement bureau charges $2 registration fee.) Box MB7-8.

GENERAL DUTY: California. Several openings in small, beautifully located hospital limited to care of medical, surgical, and obstetrical cases. Salary, $110; meals, laundry. (Placement bureau charges $2 registration fee.) Box MB7-21.

GENERAL DUTY: New England. Openings for several nurses in all-graduate staffed hospital. Highly desirable location. Salary, $80 to start. Increases. (Placement bureau charges $2 registration fee.) Box C160.

GENERAL DUTY: Midwest. Several posts open in contagious unit of 75-bed hospital. Salary, $90; full maintenance. Increase after year's service. (Placement bureau charges $2 registration fee.) Box C161.

***GENERAL DUTY:** Midwest. Small hospital with all-graduate staff. Candidate with good moral standing, good health, preferred. Knowledge of X-ray and anesthesia advantageous but not essential. Night duty every third month; half-day off a week and one Sunday a month; 8-hour duty. Salary, $75; board, laundry, room. Box NP7-1.

HEAD NURSE: West. Tuberculosis sanitorium seeks executive-type woman capable of directing activities of 42-person staff. Salary, $155; meals, private suite, laundry, garage. (Placement bureau charges $2 registration fee.) Box MB7-4.

INSTRUCTOR, NURSING ARTS: New York. Opening in 250-bed hospital. School has one class annually; 6 months' pre-clinical course, July. (Placement bureau charges $2 registration fee.) Box MB7-13.

INSTRUCTOR, PSYCHIATRIC: East. Private institution has opening for psychiatric nurse to teach 3 months' course for students affiliating in psychiatry. (Placement bureau charges $2 registration fee.) Box MB7-14.

INSTRUCTOR, SCIENCE. Midwest. Opening for science instructor with B.S. degree in 150-bed hospital. Salary, $135; partial maintenance. (Place-

**Not listed by a placement bureau.*

ment bureau charges $2 registration fee.) Box C176.

INSTRUCTOR, SCIENCE: New England. Must combine duties of assistant principal school of nursing. Minimum 2 years' experience required. Hospital and residence located on spacious grounds in pleasant section of city. (Placement bureau charges $2 registration fee.) Box MB7-15.

OBSTETRICAL NURSES: Pacific Coast. Openings for two well-trained obstetrical nurses in new air-conditioned maternity hospital. One for bedside nursing, the other for delivery-room duty. Salary, $90 to $100; meals, laundry; 8-hour day. (Placement bureau charges $2 registration fee.) Box MB7-22.

OFFICE NURSE: West. Attractively located western clinic seeks nurse with business administrative experience. Should be qualified in laboratory and X-ray technique. (Placement bureau charges $2 registration fee.) Box C170.

NURSE EXECUTIVE: South. Surgeon who is taking over directorship of new county hospital wants executive nurse-assistant. Should be qualified to administer anesthetics. Salary, $125 to $150 to begin; maintenance. (Placement bureau charges $2 registration fee.) Box MB7-5.

PEDIATRIC NURSE: Midwest. To assist supervisor in 225-bed hospital with college affiliation. Salary open. (Placement bureau charges $2 registration fee.) Box C173.

PHYSIOTHERAPIST: East. Sanatorium directed by orthopedic surgeon has opening for graduate-nurse physiotherapist. Majority of patients have chronic ailments. Recent graduate acceptable, if thoroughly competent. (Placement bureau charges $2 registration fee.) Box MB7-26.

PRINCIPAL: East. Nurse to head up school of nursing with enrollment exceeding 100 students. Responsibilities will not extend to general nursing service. Salary, $3,000; maintenance. (Placement bureau charges $2 registration fee.) Box MB7-1.

PRINCIPAL: East. Nurse executive sought for New England school of nursing averaging 60 students; well-qualified teaching staff. Comparatively small community near well-known cultural centers. Salary, $2,200; maintenance includes private suite of livingroom, bedroom, and bath. (Placement bureau charges $2 registration fee.) Box MB7-2.

SUPERINTENDENT OF NURSES: Midwest. Executive nurse with college degree for well-rated hospital located in progressive city. Salary, $190; complete maintenance, including attractive apartment. (Placement bureau charges $2 registration fee.) Box C177.

SOCIAL WORKER, MEDICAL: East. Opening for nurse social-worker in well-organized department comprised of director and four case workers. Experienced workers over 30 preferred. Salary, about $1,800. (Placement bureau charges $2 registration fee.) Box MB7-9.

SUPERVISOR, ANESTHESIA: Large teaching hospital, attractive location. Duties include administration of anesthetics, supervising and teaching student anesthetists. (Placement bureau charges $2 registration fee.) Box MB7-12.

SUPERVISOR, LABORATORY: University hospital has opening for laboratory technician, preferably with Master's degree. Must be qualified to supervise 8 staff members and teach. Duties begin

September 1. (Placement bureau charges $2 registration fee.) Box MB7-24.

SUPERVISOR, MEDICAL: West. For medical floor, 150-bed hospital, university city. Salary open. (Placement bureau charges $2 registration fee.) Box C181.

SUPERVISOR, NIGHT DUTY: Midwest. To take charge of all departments excepting ons. in attractively located Illinois hospital. Starting salary $110; maintenance. (Placement bureau charges $2 registration fee.) Box C163.

SUPERVISOR, OBSTETRICAL: East. New 50-bed department in 300-bed hospital. Opening for nurse with college degree and several years' supervising experience since completion of post-graduate work in obstetrics. (Placement bureau charges $2 registration fee.) Box MB7-18.

SUPERVISOR, OBSTETRICAL: South. Head nurse for private obstetrical ward, university hospital. Salary, $95; maintenance or privilege of living out; 8-hour day. (Placement bureau charges $2 registration fee.) Box MB7-17.

SUPERVISOR, OPERATING ROOM: East. Hospital in fairly large town on Potomac. Operations average about 200 monthly. Teaching experience in O.R. technique essential. (Placement bureau charges $2 registration fee.) Box MB7-19.

SUPERVISOR, OPERATING ROOM: East. Must be capable of assuming responsibility for 3 operating rooms, highly rated 300-bed hospital. Salary, $115; maintenance. (Placement bureau charges $2 registration fee.) Box C171.

SUPERVISOR, OPERATING ROOM: Pacific Coast. General hospital averaging 200 patients daily. Post-graduate training and several years' experience required. Salary commensurate with qualifications. (Placement bureau charges $2 registration fee.) Box MB7-16.

SUPERVISOR, PEDIATRIC: Midwest. Hospital with all-graduate staff has opening in newly completed pediatric department. Salary, $105; meals, laundry. (Placement bureau charges $2 registration fee.) Box MB7-20.

SUTURE NURSES: East. Two openings in eastern metropolitan city. Salary, $85; maintenance. (Placement bureau charges $2 registration fee.) Box C183.

TECHNICIAN: Midwest. Opening for nurse with laboratory experience for newly equipped laboratory in 70-bed hospital. Salary open. (Placement bureau charges $2 registration fee.) Box C164.

X-RAY & LABORATORY TECHNICIAN: Midwest. Busy internist seeks assistant with expert knowledge of blood chemistry. X-ray training must be unusually good to qualify. (Placement bureau charges $2 registration fee.) Box MB7-27.

X-RAY TECHNICIAN: West. Opening for nurse-technician who has worked in small hospital. Salary, $120; maintenance. (Placement bureau charges $2 registration fee.) Box C165.

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